	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SURVEY	
ANDIE	VOI COMMECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		IL6003974	B. WIÑG		C 09/08/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
HAMILT	ON MEMORIAL REHA	B & HUU	TH MARSHA SBORO, IL(
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDERICENCY)	D BE COMPLETE	
S9999	Final Observations		S9999			
	STATEMENT OF LI	CENSURE VIOLATIONS				
	300.610a) 300.1010h)					
	300.1210b) 300.3240a)					
	Section 300.610 Res	sident Care Policies				
		ave written policies and	La Mandala de la Carta de la C			
	procedures governing	g all services provided by the	Properties of the second			
desired to a constant	be formulated by a F	olicies and procedures shall Resident Care Policy				
	Committee consistin administrator, the ad	visory physician or the				
	medical advisory cor	nmittee, and representatives services in the facility. The				
1	policies shall comply	with the Act and this Part.				
	the facility and shall I	shall be followed in operating pe reviewed at least annually	Commission			
	by this committee, do and dated minutes o	ocumented by written, signed fithe meeting.				
	Section 300.1010 Me				:	
in the man	h) The facility shall no of any accident, injur	otify the resident's physician y, or significant change in a	THE PROPERTY OF THE PROPERTY O			
ı	esident's condition th	nat threatens the health, resident, including, but not				
	imited to, the presen	ce of incipient or manifest	THE PARTY IN COLUMN TO SERVICE AND ADDRESS OF THE PARTY ADDRESS OF THE PARTY ADDRESS OF THE PARTY ADDRESS OF THE P			
F	percent or more withi	weight loss or gain of five n a period of 30 days. The	Adapta na pro i popularia.			
f	acility shall obtain an	d record the physician's plan reatment of such accident,	in it then make a say	Attachment A		
	njury or change in co	ndition at the time of	To the state of th	Audumont	lialatione	
· r	notification.	A Transmission of the Control of the		Statement of Licensure \	IVIGUVII3	
	Section 300.1210 Gel Nursing and Personal	neral Requirements for				
i	ont of Bublic Health	Oare				

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

09/29/15

STATEME	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING	3.		
		IL6003974	B. WING		09/	C / 08/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY,	STATE, ZIP CODE		
HAMILT	ON MEMORIAL REHA	R & HLC:	TH MARSHA			
	OLINA MATERIA		SBORO, IL	62859		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	999 Continued From page 1		S9999			
	and services to atta practicable physical well-being of the reseach resident's complan. Adequate and care and personal cresident to meet the care needs of the reseach of a facility sharesident. (Section 2-THESE REGULATION EVIDENCED BY: Based on observation review the facility fail change and new ons for one resident (R2) residents reviewed for	pouse and Neglect se, administrator, employee or all not abuse or neglect a 107 of the Act) ONS WERE NOT MET AS on, interview and record ed to notify the physician of set of pain and manage pain in a total sample of 4 or pain. This failure resulted				
	"excruciating" and "4 three day period and regularly for pain afte	ain at a voiced level of -8" on a scale of 1-10, over a not being medicated er a fractured hip with	TOTAL PARTIES AND			
		ote dated 8/7/15 at 1:27 AM				
	being nurse station a went in to check on re resident sitting uprigh	AM, the nurse was sitting nd heard a loud noise and esident in room and found at in the floor between her			7	
. (bed and her recliner, cm x 2 cm skin tear to cleansed sit with skin	During assessment found 4 oright elbow. The nurse integrity and applied 7 sterinother skin tear measuring 2			The state of the s	

Illinois Department of Public Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE		
74160		IDENTIFICATION NUMBER	A. BUILDING		COMP	PLETED	
		II 6002074	B. WING			C	
		IL6003974	D. WING			08/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
HAMILTO	ON MEMORIAL REHA	B & HUL	H MARSHA				
	0.000		SBORO, IL	62859			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
S9999	Continued From page	ge 2	S9999				
	cm x 1 cm to lower with skin integrity ar Another skin tear no extremity measuring cleansed site with sl steri-strips. Resider discomfort. Resider and notified doctor. No documentation wo f motion was assess No documentation of per facility policy and fall incident could be E2's statement of refirst visit to emergen documentation of no Attorney) upon arrivadocumentation of no continued pain. No refall initiated. On 9/3/15 at 11:40 A Nursing) stated with assess range of mot what it is and if it was happen. E2 stated thon 8/7/15 should have check because it was the facility policy was falls. E2 stated this is pain level also On 9/8/15 at 10:00 A RN(Registered Nursenight of R2's fall had been unable to speak actually occurred or mad fall of how or if Rassessed	back. The nurse cleansed and applied 4 steri strips. Steed to anterior right lower as 4 cm x 2 cm. The nurse kin integrity and applied 6 and denied having any pain or not stated "I'm Fine. Faxed Will continue to monitor. Was found where R2's range assed after fall on 8/7/15. If neurological checks initiated a procedure for this residents of found. Wiew dated 9/8/5 shows R2's cy room has no tification of POA (Power of	S9999				
v c	vas familiar with R2 a on since her admissio	and had treated her off and on. Z3 stated at the time of	To the second se		Vertical terms of the second s		

Illinois Department of Public Health

	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY	
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		IL6003974	B. WING		09/	08/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
HAMILT	ON MEMORIAL REHA	B & HCC 609 SOUT	TH MARSHA	NLL		
		MCLEANS	SBORO, IL	62859		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPROPRICENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From page	ge 3	S9999			
fi de la constant de	her fall on 8/7/15 sh by assist but knew to trying to leave the fat this time R2 was now weight bearing due to occurred with her fall time a person has a stated she had come do therapy for R2's r Z3 stated R2 was in her of having "excreand thigh area. Z3 stor R2 as she had not before this. Z3 state therapy assistant and stated that R2 was coback, right hip and upoint she went and in shift nursing staff. Zichow R2 was assessed she tried to do anythis R2 complained of "effacial grimacing. Z3 even really turn and rhip fracture is going to On 9/3/5 at 9:30 AM, and been called to Richerapist(Z3) because the romplaints. Z4 secomplaining of a lot of she saw Z4 she was bear weight and any the was in pain and we was the was in pain and we was ractured hip then the	e was ambulatory with stand here had been issues with her acility. Z3 stated that as of w in a wheel chair and partial to the fracture of her hip that II on 8/7/15. Z3 stated any fracture it will be painful. Z3 in the morning or 8/7/15 to commate around 7:00 AM. bed and was complaining to uciating pain in her right hip stated this was very unusual ever complained of pain in her post at the physical did they both assessed R2. Z3 omplaining of pain in her pper leg. Z3 said at that mmediately notified the day 3 stated she did not know and on nights but as soon as ing as far as range of motion excruciating pain and had a stated she was unable to reposition R2. Z3 stated any to be painful. Z4 (Therapist) stated she 2's room by other e she was concerned about tated that R2 was of pain. Z4 stated at the time in bed and she could not time they tried to move her was having facial grimacing. person had a fracture or a py're going to have a lot of	\$9999			
p	ain for a while. Z4 st	ated that before R2 fell and she was up and walking				
a	round the facility with	n a walker. Z4 stated at this				
ti	me R2 was unable to	o do any type of therapy and at bearing on her right leg				

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Illinois Department of Public Health

	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAI	4 OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3:	COM	MPLETED
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		IL6003974	B. WING		09	/08/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
HAMILT	ON MEMORIAL REHA	B & HCC 609 SOUT	TH MARSHA	ALL.		
		MCLEANS	SBORO, IL	62859		
(X4) ID PREFIX	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION SHOUL	D BE	(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
S9999	Continued From pa	ige 4	S9999			
		-	00000			
	due to her fractured					
	8/7/15 impression e	gency room X-ray report dated shows: lucency right greater				
	trochanter favored	to be artifactual, with				
		re not entirely excluded.				
		relation with radiography right		7000		
	hip or CT (compute	d tomography) for further				
	evaluation. Doctor	aware and wants R2 sent				
		ne and monitor and do CT if				
	not better in two day					
:		ion Administration Record) for				
		resident complaining of pain				
		3" on a scale of 1-10 for		99000		
	(Sunday) No docum	15 (Saturday), 8/9/15 mentation can be found were				
		vare of increase in resident's				
		on 8/7/15. Review of R2's				
		and 8/1-7/15 has her normal				No. of the contract of the con
		Note dated 8/10/15 at 10:25				
		resident continues to				
	complain of pain to r	right hip and leg.				
	R2's document titled	CT right hip without contrast				
		under impression mildly				
ĺ	displaced fracture of					
		ealth Status Note dated				7.70
	8/14/15 at 12:19 PM	es have a right him fracture				
	appointment and doc	es have a right hip fracture, out very painful break, may	1			
		artial weight bearing as	and the same			
and the state of t	tolerated to right foot					
		ent titled "Neuromuscular				- Linear Control
		dated 8/14/15 shows she				
		re of her right hip. Healing				
	will take 6-12 weeks.	. Will allow her to be partial				
		er right lower extremity as				4 4 5 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6
	tolerated. She is goi	ng to be at reduced activity				
	level for a while beca		To a second			
		M, E2 DON stated she did				
	not know why the nui	rsing staff over the weekend				

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER:	1			PLETED
				***************************************	X-	^
		IL6003974	B. WING		1	C 08/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
T	ON MEMORIAL BELLA	600 0011	TH MARSHAL			
HAMILI	ON MEMORIAL REHA	n & H.C.	SBORO, IL 6			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	HE APPROPRIATE	COMPLETE DATE
S9999	Continued From pa	ge 5	S9999			
	of 8/7/15 to 8/9/15 c	lid not make the doctor aware				
	of R2's increase and	d change in pain after her fall	en e			
į	on Friday 8/7/15. F	2 stated that the nursing staff	and the second			
	should not have wai	ted all weekend and allowed				
	R2 to have been ex	periencing pain at such a high				
	level. E2 stated that	she did not feel R2's order				
		was going to be effective for	The showing			
ĺ	R2 type of pain cons	sidering R2 probably had a	77-000			
	fractured hip at that	time. E2 stated she had	0000			
	questioned her nurs	ing staff as to why they had				
	not notified the phys	ician and had not been given				MI 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	and answer. E2 sta	ited this was obviously a				E pro-
	problem and she wa	s trying to resolve it and pain				
	should always be tre	ated and treated with a				
	medication that is m	ost effective and the doctor				100
	should be notified im	mediately of any change as				
	soon as needed. E2	stated a hip fracture can be				THE PARTY OF THE P
	very painful and stro	nger pain medication than	TO CONTRACT OF THE PARTY OF THE			
	acetaminophen woul	d be needed to alleviate the	A de la companya de l			
	pain. E2 stated that i	s why she had made sure				
	tne physician was ca	lled on 8/10/15 for an order	The Artistance			
	for the pain medication	on Norco. E2 stated her				
	expectation was that	R2 was being given this				
	the poin related to the	regular basis because of				
	that the orthogodist h	is fracture. E2 confirmed				
	nature orthopeust r	ad also stated this was a vould cause a change in her				
	wheelchair and nor	this time R2 was mobile with tial weight bearing to her				
r	right leg and not to a	mbulate and no therapies at				
+	his time and to have	assist with all transfers.				
Ċ	On 9/3/15 at 10:20 A	M, E9 CNA (Certified				
1	Nursing Assistant) wa	as in R2's bathroom and had				
r	er on the toilet. F9 I	nad no gait belt on R2. E9	THE PERSON NAMED IN COLUMN NAM			
s	tated R2 had gotten	herself out of her bed and	A. HOUSE, A. C. L.			
מ	out herself in her whe	elchair. E9 stated that				
N	hen she entered R2	's room her body alarm was	on account of			
q	oing off and R2 had	managed to transfer self	Of distance of the latest and the la			
fr	om bed to wheelcha	ir in that time. E9 then				
р	roceeded to transfer	R2 from the toilet to the	manus dos			

Illinois Department of Public Health

STATE FORM

Illinois Department of Public Health

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE	SURVEY
ANDPLAN	N OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G:	COMPLETED	
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		120003974	<u> </u>		09/0	08/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
LIAMII T	ON MEMORIAL BELLA	5 8 4 4 5 609 SOUT	TH MARSHA	ALL		
HAMILI	ON MEMORIAL REHA	8 & M.C.	SBORO, IL			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	781	i
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
			- Total	DEFICIENCY)		
S9999	Continued From pa	ge 6	S9999			
		gait belt. R2 was noted to right leg and had facial	and an activity			
		transferred R2 from her	POST (CONTRACT)			
		ed without the use of a gait				
		noted to bear weight on her				
	right leg and had fac	cial grimacing				
		AM, E9 CNA stated she				
		nsferred R2 without a gait belt				
	and there is a great	change for injury to the				
	resident. E9 gave no	o indication she was aware of				
	facial grimacing and	indications of pain during				
7	transfers and weight	t bearing.				
		M, E5 LPN(Licensed				
	Practical Nurse) stat	ted that any time a staff				
		a gait belt should be used.				
	E5 stated R2 was pa	artial weight bearing status to				
		ecent fractured hip. E5				
	stated the last time s	she had a Norco pain pill was				
	8/16/15. At this time	survey made E5 aware R2]
	had been transferred	by E9 without gait belt and				
		pain assessments need to be				
		n assessment is done every				
		you if she is hurting.	an and an			
		PM, E2 DON, stated E9	3		-	l
		vithout gait belt for resident cial grimacing is an indicator			And the state of t	I
		e assessed. E2 stated R2 is	-		77	
		pain due to recent fracture				
		sed for pain on on-going				
		his time R2 is only to be				
		g on right leg due to fracture.				1
		ealth Status Note dated			i	1
		ows at 7:55 PM resident			-	
		peside her bed. She had			To any other state of the state	****
a	apparently put hersel	f to bed and was attempting			THE PARTY OF THE P	
t	o get back up into he	er wheelchair and the brakes				
V	were not locked. She	states that she does not				
ŀ	nurt anywhere, but sh	ne has a 3 cm scratch				
b	pehind her ear on the	e left side of her head.				
		L E2 DON stated that she				i

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Illinois Department of Public Health

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED	
		IL6003974	B. WING		8	C 08/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY	STATE, ZIP CODE	<u> </u>	
		600 50117	H MARSH			
HAMILTO	ON MEMORIAL REHA	Bancc	BORO, IL			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
	she had come in thi that when she aske management that the (Registered Nurse) her "regular pain". why R2 was having "regular pain" when assessing R2 for particular answer her question not aware that R2 have	investigation to this fall when s morning. E2 also stated d about R2's pain he nurse on duty E8 RN stated that R2 was just having E2 stated she asked E8 " any pain " let alone in the nursing staff was to be in every shift and R2 had pain e. E2 stated E8 was unable to he when questioned E2 was ad not received any pain 16/15. E2 stated R2 should				
	have been receiving the orthopedic docto that's why she (E2) I but apparently after and 9/6/15 the staff needs to be address needs to be done wi pain is not being ma On 9/8/15 at 1:00 PM (Medication Adminis	some kind of pain relief per ors recommendations and nad gotten the Norco order the incident with R2 on 9/3/15 do not understand how pain sed and obviously education th all staff. E2 stated R2's				
	assessment. No documber resident was a indicators of pain aftimproper transfer on aware. Review show 8/16/15. R2's Health Status Nowent to orthopedic apreview of R2's MAR administered prior to at 2:00 PM, E2 states and a control of the prior to her appointm Dn 9/8/15 at 2:00 PM	cumentation was found assessed or medication for er facial grimacing with 9/3/15 and staff was made as last Norco was given on lote dated 8/14/5 states R2 appointment at 9:10 AM, shows no pain medication this appointment. On 9/8/5 d nursing staff should have be pain medication Norco ent for pain management. I E2 stated nursing staff ed R2 for pain after her fall				

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	it	СОМ	PLETED
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***************************************		IL6003974	B. WING		ł	C 09/2045
		120000014	L		09/	08/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
LIANNII TO	ON MEMORIAL REHA	B & UCC 609 SOUT	H MARSHA	LL		
HAWILI	ON WEWORIAL REMA	MCLEANS	SBORO, IL	62859		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)NI	(3/5)
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIES	PIATE	DATE
				DEFICIENCY)		
S9999	Continued From page	ae 8	S9999			
		te dated 9/5/15 at 5:44 shows				
		ctive range of motion,				
	holt and and anciet	room in the evening with gait				
		she is compliant with				
		g. On 9/8/5 at 3:00 PM, E2	0			
		partial weight bearing to right				
İ	walked on 0/5/15 w	when questioned about being as unable to answer.				!
						1
A CONTRACTOR	According to the fac	ol " dated 5/13 under				i
İ		igement it shows that based				
		sessment, the staff and				
		y pertinent interventions to try				
1	to prevent subseque	ent falls and to address risks				
		nces of falling. The staff,				
		guidance will follow up on				
		ted injury until the resident is				
		complications such as late				
	fracture or subdural	hematoma have been ruled				
	out or resolved. Del	ayed complications such as				
	late fractures and ma	ajor bruising may occur hours				
	or several days after	a fall, while signs of				
:	subdural hematomas	s or other intracranial				
		up to several weeks after a				
	fall					
	According to the faci					
		ol "dated 5/13 shows the				
		ess each individual for pain				
\	whenever there is a	significant change in	-			
		here is onset of new or				
		pain. The staff will identify				
	ne nature and chara	cteristic such as location,				
	ritensity, frequency,	pattern, etc. as well as				
		staff will observe the				:
		and movement) for evidence				
		grimacing while being	ĺ			
-	epositioned. The sta or interventions wher	off will identify any situations	0			
		e anticipated: for example ion. The staff and physician	William Control			
	annoulation of reposit	ion. The stair and physician				1

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ı	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION S:		(X3) DATE SURVEY COMPLETED	
		IL6003974	B. WING	0	1	C 08/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY	STATE, ZIP CODE		30/20 10	
		600 60117	H MARSHA				
HAMILTO	ON MEMORIAL REHA	BAHCC	SBORO, IL				
/Y4\ ID	SILMMADV STA	TEMENT OF DEFICIENCIES				Ţ	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
S9999	Continued From page	ge 9	S9999				
	will also evaluate he activities of daily livi quality of life, includ disturbance, social in According to the fact Documentation" dat provided to the residents medical or documented in the representations, mediciperformed, etc., must resident clinical recommendations.	ow pain is affecting mood, ng, sleep, and the resident's ing complications such as gait	29999				
- ALLES AND AND AND AND AND AND AND AND AND AND	(B)	The state of the s					
	300.610a) 300.1210a) 300.1210b) 300.3240a)						
	Section 300.610 Res	sident Care Policies					
	procedures governin facility. The written pose formulated by a Rommittee consisting administrator, the admedical advisory controller shall comply the written policies shall the facility and shall the toy this committee, do and dated minutes of the facility and shall the toy this committee, do and dated minutes of the facility and shall the fa	g of at least the visory physician or the nmittee, and representatives services in the facility. The with the Act and this Part. hall be followed in operating be reviewed at least annually ocumented by written, signed the meeting.					
	Section 300.1210 Ge	neral Requirements for					

	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION 3:	(X3) DATE SURVEY COMPLETED	
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		IL6003974	B. WING		09/0	8/2015 ⁰
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HAMILT	ON MEMORIAL REHA	D & UCC	TH MARSHA SBORO, IL			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICENCY)	.D BE	(X5) COMPLETE DATE
S9 99 9	Continued From page	ge 10	\$9999			
	Nursing and Person	nal Care				
	a) Comprehensive F with the participation resident's guardian applicable, must descomprehensive care includes measurable meet the resident's rand psychosocial neresident's comprehe allow the resident to practicable level of in provide for discharge restrictive setting barneeds. The assessmanthe active participation resident's guardian capplicable. (Section in the section of the section in the	Resident Care Plan. A facility, nof the resident and the or representative, as velop and implement a eplan for each resident that e objectives and timetables to medical, nursing, and mental eds that are identified in the ensive assessment, which attain or maintain the highest ndependent functioning, and eplanning to the least sed on the resident's care nent shall be developed with on of the resident and the or representative, as				³
	b) The facility shall prand services to attain practicable physical, well-being of the resident's complan. Adequate and pare and personal care and personal care needs of the resident to meet the res	rovide the necessary care nor maintain the highest mental, and psychological dent, in accordance with prehensive resident care properly supervised nursing are shall be provided to each total nursing and personal sident.				
; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ;	Section 300.3240 Ab a) An owner, licensee agent of a facility sha resident. (Section 2-1	a, administrator, employee or			TOTAL THE STATE OF	
_	THESE REGULATION	NS WERE NOT MET AS				

	MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY	
	. W. G. GOTHLEGHON	DEIVI IONION HOMBER	A. BUILDING:		COMPLETED	
		 IL6003974	B. WING		1	C
***************************************					1 09/0	08/2015
NAME (OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HAMII	TON MEMORIAL REHA	BAHCC	TH MARSHAI SBORO, IL 6			
(X4) II	SUMMARY STA	TEMENT OF DEFICIENCIES				7
PREFI TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
S999	9 Continued From pa	ge 11	S9999			
	EVIDENCED BY:		MAN TO A SECTION OF THE SECTION OF T			
	Based on observation review the facility facilit	cility policy and procedures to uries for 4 residents (R1-4) in reviewed for accidents and a resulted in R2 sustaining a set caused the resident to go bulatory status to a partial as and reduced activity lan of Care with initiation date a goal date of 11/17/15, R2 is d to falls prior to admission. Sessment. Fall 6/20/15, Fall and falls thru the review date attion of this goal is 5/5/15. R2				

Illinois Department of Public Health STATE FORM

Illinois Department of Public Health

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
ANDFLA	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING):	COMPLETED			
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0		IL6003974	B. WING		1	C		
		10003974			09/	08/2015		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE				
: : A N A T/	AN MEMORIAL RELIA	609 SOUT	TH MARSHA	ALL.				
HAMILI	ON MEMORIAL REHAI	n & H.J.	SBORO, IL					
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES				***************************************		
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE		
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE		
			The state of the s	DEFICIENCY)				
99999	Continued From page	20.12	S9999					
00000		-	29999	TO A COLONIA				
	and pushed lever do	own to remove chair from	And the second s					
	reclining position. D	Ouring assessment found 4						
:	cm x 2 cm skin tear	to right elbow. The nurse						
	cleansed sit with ski	n integrity and applied 7 steri						
	strips. Nurse found a	another skin tear measuring 2						
	cm x 1 cm to lower b	pack. The nurse cleansed						
	with skin integrity an	d applied 4 steri strips.						
	Another skin tear no	ted to anterior right lower						
	extremity measuring	4 cm x 2 cm. The nurse						
	cleansed site with sk	kin integrity and applied 6						
of 4 to 1	steri-strips. Residen	nt denied having any pain or						
		nt was laughing and stated "				į.		
		irt anything except for my						
-	elbow. I didn't hurt n	ny head. I just thought it was						
	time to get up for the	day. " Complete skin						
	assessment perform	ed and helped to transfer						
	resident back into be	ed. Applied body alarm						
	underneath resident	while in bed. Applied derma						
	savers to upper extre	emities to protect site. Called						
1 H	and notified Z8 (POA	(#1) about incident. Faxed						
	and notified doctor. 1	Will continue to monitor.						
!	No documentation wa	as found where R2's range						
1.1	of motion was asses:	sed after fall on 8/7/15.						
	There were also no d	locumentation of						
1	neurological checks i	nitiated per facility policy and						
	procedure for this res	sidents fall incident.	P. Control					
		M E2 DON (Director of						
		any fall staff should all	A CONTRACTOR OF THE CONTRACTOR					
6	assess range of moti	on and should document	OR OLD A SECOND		5	1		
1	what it is and if it was	not documented it did not				l		
ŀ	nappen. E2 stated the	e nurse on duty when R2 fell				ļ		
C	on 8/7/15 should have	e initiated a neurological						
C	check because it was an unwittnessed fail and							
t	he facility policy was	to initiate with unwittnessed						
f	alls. E2 also stated w	with the neurological checks						
įt	he resident is checke	ed on more often by the	İ		į			
∍	nurse of should be.					1		
. (On 9/8/15 at 10:00 Af	M E2 DON stated E11						
F	RN(Registered Nurse) that had been on duty the			1			
n	ight of R2's fall had s	since resigned and she had	!			uppe		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		I (VO) MILL TIE	A F CONCERNATION	Torri 5 17	—	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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					l c	
		⁰ IL6003974	B. WING		09/	08/2015
NAME OF	PROVIDER OR SUPPLIER	CTDEET AD	DDESS CITY	STATE, ZIP CODE	According to the second	
NAME OF	THOUBEROR SOFFLIER					
HAMILT	ON MEMORIAL REHA	B & HCC	TH MARSHA			
	·		SBORO, IL	62859		
(X4) ID		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
		•	17.0	DEFICIENCY)		
S9999	Continued From pa	ac 12	S9999		····	
39999			39999			
		ak to her regarding what had	a de la companya de l			
		not occurred the night R2				
	had fall.		TOTAL PROPERTY OF THE PROPERTY			
	On 9/3/15 at 11:40 /	AM, E2 DON was unable to	naeroayonay.			
	answer why the doc	ctor was faxed instead of	TO STATE OF THE ST			
		egarding R2's fall when there				
		with treatments provided.				
		AM, E2 DON stated R2 had				
		checks for safety and				
		nfirmed when staff did these				
		also be checking for any				
		ricinity of the resident. E2				
		not know why R2's recliner If this is something staff				
		during the safety checks. E2				
		the recliner foot rest not been				
		ve fallen or the risk would				
		ecreased. E2 stated the				
		nly have contributed to the				
1	increase in the injury					
		PM, E2 DON stated that R2's				
		re to be done as marked at				
		could not explain why on the				
		that three hours of 30 minute				
		cumented at the same time.				
		e same time. E2 stated there				
		mine if R2 was actually being				
		minutes or not. E2 stated				
		determine or confirm that				
		vere actually done per the				
	facility policy and pro	ocedure	and the same of th			
		view dated 9/8/5 shows R2's	and the same			
	first visit to emergen					
		tification of POA(Power of	7.00			
		al back to facility. No				l
		tification over weekend of				
		neurological checks on R2's				
	fall initiated.	Autorici po				
		//, Z3(Therapist) stated she			1	
was familiar with R2 and had treated her off and						

Illinois Department of Public Health

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	S:	COMPLETED	
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		120003974			09/0	08/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
		609 SOUT	H MARSH	Δ1 I		
HAMILTO	ON MEMORIAL REHA	Bancc	SBORO, IL			
	0.00.00.00.00.00.00.00.00.00.00.00.00.0		JOOKO, IL			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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		,	IAG	DEFICIENCY)		3.02
2222	A .:					
\$9999	Continued From page	ge 14	S9999			
	on since her admiss	sion. Z3 stated at the time of				
1	her fall on 8/7/15 ch	e was ambulatory with stand				
	hy agglet but know t	here had been issues with her				
	maniforing her over	acility so they had been				
	stated that as of this	y so often because of this. Z3				
		s time R2 was now in a wheel				
	Criali and partial wel	ight bearing due to the				
	racture of her hip th	nat occurred with her fall on				
1	8/7/15. I.	,				
To the second	On 9/3/5 at 9:30 AM	, Z4 (Therapist) stated the				
		2 she was in bed and she				
		nt and any time they tried to				
	move her she was in	n pain and was having facial				
	grimacing. Z4 state	d any time a person had a				
	fracture or a fracture	ed hip then they're going to				
	have a lot of pain for	a while. Z4 stated that				
1	before R2 fell and fra	actured her right hip she was				
	up and walking arou	nd the facility with a walker.				
	Z4 stated at this time	e R2 was unable to do any				
	type of therapy and v	was only partial weight				
	bearing on her right	leg due to her fractured hip.				
	Z4 stated anytime sh	ne went into a room as a		TOTAL BARROWS		1
	therapist she tried to	asses for hazards and a				
	chair with a footrest	out with definitely be a cause				
1	for a concern for her	. Z4 stated if she went into a				l
1	room and a recliner l	had a footrest up she would				
	go put it down and m	nove it away from the bed				
		dent had a safe path to walk				
	to the doorway in.	•				
	According to Emerge	ency room X-ray report dated				
8	8/7/15 impression sh	lows: lucency right greater				
	rochanter, favored to				ļ	
	nondisplaced fracture not entirely excluded. Recommended correlation with radiography right hip or CT(computed tomography) for further				of operation of	
F						
		ware and wants R2 sent				
		e and monitor and do CT if				1
	not better in two days					l
1	ior better in two days	J.				
	22'e Health Status N	ote dated 8/10/15 at 10:25				
F	VE 3 LICARIT STATUS IN	ole dated 6/10/15 at 10:25				1

Illinois Department of Public Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION		E SURVEY PLETED	
		A. BUILDING:				
		D WING		1	С	
		IL6003974	B. WING		09/	08/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
LIABALLT	ON MEMORIAL REHA	609 SOUT	TH MARSHA	ALL .		
HAMILI	ON MEMORIAL RENA	MCLEAN:	SBORO, IL	62859		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ne 15	S9999			
00200	•		00000			
		resident continues to	7	TOTAL PROPERTY.		
		right hip and leg. Resident is				
		on right leg during transfers. d CT right hip without contrast				
		d under impression mildly				
	displaced fracture o		A Company of the Comp	•		
		ealth Status Note dated	Villa Joseph			
	8/14/15 at 12:19 PM					
		es have a right hip fracture,		0		
		out very painful break, may		·		
		artial weight bearing as				
	tolerated to right foo					
		ent titled " Neuromuscular " dated 8/14/15 shows she				
		re of her right hip. Healing				
		. Will allow her to be partial				
		er right lower extremity as				
		ing to be at reduced activity	And the same of th			
	level for a while beca					
		AM, E9 CNA (Certified	11			
		as in R2's bathroom and had				
		had no gait belt on R2. E9				
ļ		n herself out of her bed and eelchair and because she				
		vement on herself. E9 stated				
		ed R2's room her body				
		and had been going off but	į			
		ng another resident and did				
	not want to leave the	m unattended and had				
		as possible but, R2 had				
		self from bed to wheelchair				
		proceeded to transfer R2	Old American and the Control of the			
		wheelchair with no gait belt. r weight on her right leg and	P Militare concess		I I	l
		E9 then transferred R2				
		to her bed without the use of				
		was noted to bear weight	70 4 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5			
	on her right leg and h					
		M, E9 CNA stated she				
should not have transferred R2 without a gait belt		*				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY	
AND I DIVING OF THE STATE OF TH		A. BUILDING	:	COMPLETED		
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		IL6003974	B. WING		09/08	3/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
HAMILTO	ON MEMORIAL REHA	B & HCC 609 SOUT	TH MARSHA	LL		
		MCLEAN	SBORO, IL	62859		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9999	Continued From pa	•	S9999			
	and there is a great	change for injury to the	900000000000000000000000000000000000000			
		o indication she was aware of dindications of pain during	. Or company			
	transfers and weigh		A PARTIE DE LA PAR			
		AM , E5 LPN(Licensed	THE STREET			
		ted that any time a staff				
		s a gait belt should be used				
		ears an alarm whether it 's a				İ
		larm should respond. E5		0		
		re not nursing they can at re the resident is safe. E5				
-		m is going off long enough for				
	a resident to make i	t from the bed to a chair or a				
	chair to bed then it p	probably is going off to long				
	and staff should be	responding quicker. E5				
	stated R2 was partia	al weight bearing status to				
		ecent fractured hip. E5				I
ĺ	Stated the last time s	she had a Norco pain pill was				
	had been transferred	e survey made E5 aware R2 d by E9 without gait belt and				
		pain assessments need to be				
		n assessment is done every				
		you if she is hurting.				
	On 9/3/15 at 12:40 F	PM, E2 DON, stated if alarm	TO STATE OF THE ST			I
	is going off long eno	ugh for resident to transfer				
		r or chair to bed then staff is	000			1
	not responding quick	kly enough and any staff can n and should respond for				I
1	resident safety F2 (stated E9 should not transfer				
,	without gait belt for r	esident safety. E2 stated				
ı	facial grimacing is ar	n indicator of pain and should				
ł	pe assessed. E2 sta	ated R2 is at increased risk				
f	or pain due to recen	t fracture and should be				1
		on-going basis. E2 stated				
		y to be partial weight bearing				
	on right leg due to fra					
<i>F</i>	According to K's Hea	alth Status Note dated 9/6/15 7:55 PM resident found				
	at 6.20 PM shows at sitting in floor beside					
a	apparently put hersel	If to bed and was attempting				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
×		IL6003974	B. WING			C 08/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
HAMILT	ON MEMORIAL REHA	B & HCC	H MARSHA			
(X4) ID	SHIMMADY STA	TEMENT OF DEFICIENCIES	SBORO, IL			·
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9999	Continued From page	ge 17	S9999			
	were not locked. She hurt anywhere, but she behind her ear on the	ner wheelchair and the brakes ne states that she does not she has a 3 cm scratch the left side of her head. Fort dated 9/6/15 at 7:55 PM was turned off.				
	R2 continues with ac ambulates to dining belt and one assist, exercise and walking stated R2 was still pa	re dated 9/5/15 at 5:44 shows betwee range of motion, room in the evening with gait she is compliant with g. On 9/8/5 at 3:00 PM, E2 artial weight bearing to right hen questioned about being s unable to answer.				
	8/8/15 at 8:40 AM, sl lying on ground face Under miscellaneous alarm was not on. Ur at 7:49 PM shows Rher wheelchair, R1 sl and small skin tear to has increased in size On 9/3/15 at 12:10 P to the POA the past with the aware that after that she had determine fault that R1 had falle that occurred on 2/13 stated that according have her alarm on who was not on. R2 state of this.	M E2 stated she had spoken veekend (9/1/15) and made r her follow up to R1's fall ned it was the facility staff 's in out of her chair on her fall 1/15 as well as 8/8/15. E2 to R1 's care plan she is to nile in her wheelchair and it d she made the POA aware re plan with initiated date of				
	5/13/15, R1 is risk for mobility with falls on 2	falls related to impaired 2/13/15 and 8/9/15. Under alarms to bed and chair.			migra objectiva sem s mes sumbalas ari	

Illinois Department of Public Health

NAME OF PROVIDER OR SUPPLIER NAME OF PROVIDER OR SUPPLIER NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, JUP CODE 69 SOUTH MARSHALL MILEANDSBORO, IL 62859 PROVIDERS PLAN OF CORRECTION (XA) ID SUMMAN'S YATELEAST OF DEFCIENCES TAG SOUTH MARSHALL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMAN'S YATELEAST OF DEFCIENCES TAG CROSS REFERENCED TO THE APPROPRIATE ORDITION SOUTH MARSHALL RECULATORY OR LSC IDENTIFYING INFORMATION) SOUTH MARSHALL RECULATORY OR LSC IDENTIFYING INFORMATION TAG CROSS REFERENCED TO THE APPROPRIATE OATE OATE OATE SOUTH MARSHALL RECULATORY OR LSC IDENTIFYING INFORMATION) SOUTH MARSHALL RECULATORY OR LSC IDENTIFYING INFORMATION TAG OR STREEFRENCED TO THE APPROPRIATE OATE STATEME	NT OF DEFICIENCIES	(V1) DDOV/DED/SUDDIJED/OUA	(VO) N. II II TIPO	CANATALIATION			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 109/08/2015 SUMMARY STATEMENT OF DEPOCENCIES PREFIX TAQ SUMMARY STATEMENT OF DEPOCENCIES PREFIX TAQ SUMMARY STATEMENT OF DEPOCENCIES PREFIX TAQ SUMMARY STATEMENT OF DEPOCENCIES PREFIX TAQ SUMMARY STATEMENT OF DEPOCENCIES PREFIX TAQ CERCULTORY OR LSC IDENTIFYING INFORMATION) S9999 Continued From page 18 3. According to R3's Care Plan with date initiated of 4/30/15, R1 is at risk for falls related to unaware of safety needs, gaibbalance problems with falls on 5/9/15 and 5/13/15. Interventions stated R3 is to have wedge cushion to wheelchair for positioning. On 9/1/15, 9/3/15 a 9/8/15, R3 was seen in various areas throughout the facility and did not have designated wedge cushion in her wheelchair. On 9/8/15 at 9.30 AM, R3 was in the physical therapy room and Z3 (therapist) was with her and was sitting in same cushion previously noted. Z3 stated that the cushion R3 was on was not a wedge cushion but a standard cushion and that R3 was not positioned well because she was at the edge of her seat and this would make her more like to slide out of her chair. R4 4. According to R4's Care Plan with initiated of 3/16/15 shovs R4 is at risk for falls related to hip fracture with falls on 3/2/115, 5/18/15, 6/11/5, 6/8/16, 6/11/15, 7/11/5, 8/21/15 and 8/30/15, Intervention for R4 to use a bedichair electronic alarm and ensure the device is in place as needed and working correctly with initiation date of 7/10/15. On 9/3/15 at 10:11 AM R4's chair alarm started sounding. No staff responded to R4's alarm until 10:16 AM. When staff responded to her wheelchair. According to the facilities policy titled "Falls-Clinical Protocol dated 5/13" under treatment and management it shows that based on the preceding assessment, the staff and physician will identify pertinant interventions to try to prevent subsequent falls and to address risks			I have				
IL.6003974 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STATE, ZIP CODE 609 SOUTH MARSHALL MCLEANSBORO, IL. 62859 (IRACH DEFIDIENCY MUST SE PRECEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG SUMMARY STATEMENT OF DEFIDIENCIES TAG SUMMARY STATEMENT OF DEFIDIENCIES TAG SUMMARY STATEMENT OF DEFIDIENCIES TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFIDIENCIES TAG PREFIX TAG TAG PREFIX TAG PREFIX TAG PREFIX TAG TAG PREFIX TAG TAG TAG TAG TAG TAG TAG TAG TAG TAG	IDENTIFICATION NORMALIA		A. BUILDING:		CON	COMPLETED	
IL.6003974 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STATE, ZIP CODE 609 SOUTH MARSHALL MCLEANSBORO, IL. 62859 (IRACH DEFIDIENCY MUST SE PRECEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG SUMMARY STATEMENT OF DEFIDIENCIES TAG SUMMARY STATEMENT OF DEFIDIENCIES TAG SUMMARY STATEMENT OF DEFIDIENCIES TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFIDIENCIES TAG PREFIX TAG TAG PREFIX TAG PREFIX TAG PREFIX TAG TAG PREFIX TAG TAG TAG TAG TAG TAG TAG TAG TAG TAG							C
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				1	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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PR	4) ID EFIX AG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDENCY)	D BE	(X5) COMPLETE DATE	
SS		fall with associated stable and delayed fracture or subdural out or resolved. De late fractures and mor several days after subdural hematoma bleeding could occur fall. According to the fact Pain-Clinical Protoconursing staff will associated whenever there is a condition and whenever there is a condition and whenever there is a condition and whenever the and charation of existing the nature and charation for example, repositioned. The state of pain: for example, repositioned. The state of pain: for example, repositioned and the resident's pain may be ambulation or repositional will also evaluate how activities of daily livinguality of life, includinguality of life, includinguality of life, includinguality of life, includinguality of the facil Documentation dated or ovided to the resident esidents medical or documented in the reposervations, medical performed, etc., must esident clinical recording to the facil provided to the resident enterior of the conditional recording to the second of the resident esident clinical recording to the resident esident clinical recording to the resident element of the resident element	guidance will follow up on any injury until the resident is complications such as late hematoma have been ruled layed complications such as rajor bruising may occur hours a fall, while signs of its or other intracranial rup to several weeks after a dility policy titled " or "dated 5/13 shows the ess each individual for pain significant change in there is onset of new or grain. The staff will identify acteristic such as location, pattern, etc. as well as staff will observe the and movement) for evidence grimacing while being aff will identify any situations are an increase in the one anticipated: for example tion. The staff and physician we pain is affecting mood, g, sleep, and the resident's and complications such as gait	S9999				

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		R/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COM	COMPLETED				
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Illinois Department of Public Health STATE FORM